ADVANCED DERMATOLOGY & SKIN CANCER CENTER
MEDICAL HISTORY

NAME: _____
DATE OF BIRTH: _____

Please circle Y or N

Currently Using:

Aspirin/Motrin/Advil	Y N	Birth Control Pills	Y N	Are you pregnant?	Y N
Coumadin	Y N	Are you breastfeeding?	Y N	Plan on becoming pregnant?	Y N

Review of Systems (current or past problems with)

Blood/Bleeding Disorders	Y N	Arthritis	Y N	Pre-cancerous Lesions	Y N
Heart Disease	Y N	Diabetes (sugar)	Y N	Cancer (non-skin)	Y N
Kidney Disease	Y N	High Blood Pressure	Y N	Skin Cancer	Y N
Liver Disease or Hepatitis	Y N	Thyroid Disease	Y N	(If Yes) Location _____	
Lung Disease	Y N	Neurologic Disorders	Y N	If Yes) Type _____	
Lupus	Y N	MS	Y N		

Do you:

Have a pacemaker or defibrillator?	Y N	Get a yearly Flu Vaccination	Y N
Have an artificial joint or heart valve?	Y N	(if yes) Last Injection Date:	___/___/_____
Take antibiotics prior to surgical procedures?	Y N	Have you had a Pneumonia Vaccination	Y N
Form keloids?	Y N	(if over 65) Last Injection Date:	___/___/_____
Do you consume alcohol?	Y N		
How much per day? _____			

Any conditions your doctor should know about?

_____

_____

Family History (check the following medical conditions which have occurred in your family:

	Self	Mother	Father	Blood Relative
Acne	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Eczema	☐	☐	☐	☐
Hay Fever	☐	☐	☐	☐
Lupus	☐	☐	☐	☐
Melanoma	☐	☐	☐	☐
Psoriasis	☐	☐	☐	☐
Skin Cancer	☐	☐	☐	☐

Patient Signature _____ Date _____
(Parent/guardian's signature if patient is a minor)

Physician Signature _____ Date _____